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An Independent Review Organization

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Notice of Independent Review Decision

Case Number ***Date of Notice:*** 09/29/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Physical Therapy 3 X wk X 6 wks lumbar spine

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male whose date of injury is XX/XX/XX. The mechanism of injury is described as putting away POS and pulling and felt a slight pull in the back after the picker bounced and stepping off. Note dated 12/16/14 indicates that the patient previously had 2 surgical interventions with discectomy/fusion. Fusion has failed as has hardware. Office visit note dated 06/05/15 indicates that the patient presents for follow up for lumbar pain status post fusion. The patient reports he has been losing weight and walking more. He would like to discuss getting lumbar injections. Current medications are amitriptyline, baclofen, gabapentin, Lyrica, and Flector. Low back pain is rated as 6/10. On physical examination the patient ambulates without difficulty. There is bilateral paravertebral tenderness to palpation and decreased range of motion to rotation and flexion. Diagnoses are acquired spondylolisthesis, thoracic/lumbosacral neuritis/radiculitis, spondylosis with myelopathy, sprain/strain knee and leg, postlaminectomy syndrome lumbar region. Office visit note dated 06/12/15 indicates that the patient presents with right hand numbness and tingling since September. On physical examination there is no instability, dislocations in the joints or digits of the hand. There is no thenar muscle wasting. There is no hypothenar muscle wasting. Tinel's, Durkan's and Phalen's are positive at the wrist. The grind test and shuck test are negative. Assessment notes carpal tunnel syndrome. Daily note dated 07/02/15 indicates diagnosis is lumbago.

Initial request for physical therapy 3 x wk x 6 wks lumbar spine was non-certified on 08/17/15 noting that the patient has attended an unknown number of therapy sessions to date. There was no complete set of physical therapy notes submitted, by which plateauing and progress might be assessed. There are no objective indications of progressive, clinically significant improvement from prior therapy. Continuation of therapy should be predicated on a formal assessment validating improvement in function at intervals of 6 sessions. There is no indication as to why supervised therapy is required for this patient. The patient should be proficient in a home exercise program. The denial was upheld on appeal dated 08/24/15 noting that according to ODG, 9 visits of physical therapy would be supported for lumbago and 10 visits for intervertebral disc disorders. The patient complains of low back pain. The patient was diagnosed with lumbago. The clinical notes do not provide sufficient objective information regarding why physical therapy is being requested at this time. It is unclear if this is related to the lumbar fusion or for chronic back pain only.
There are no previous visible therapy notes, occupational therapy notes or chiropractic therapy notes included for review. There are no barriers to continued conservative management or home exercises.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient sustained injuries in xxxx. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient has undergone multiple lumbar surgeries; however, there is no information provided regarding surgical intervention to include dates of service and procedures performed. The number of physical therapy visits completed to date is not documented. There are no serial physical therapy records submitted for review documenting the patient's objective functional response to therapy in order to establish efficacy of treatment and support additional sessions. There is no current, detailed physical examination of the lumbar spine submitted for review and there are no specific, time-limited treatment goals provided. The request is excessive and does not allow for adequate interim follow up to assess the patient's response to treatment. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for physical therapy 3 x wk x 6 wks lumbar spine is not recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)